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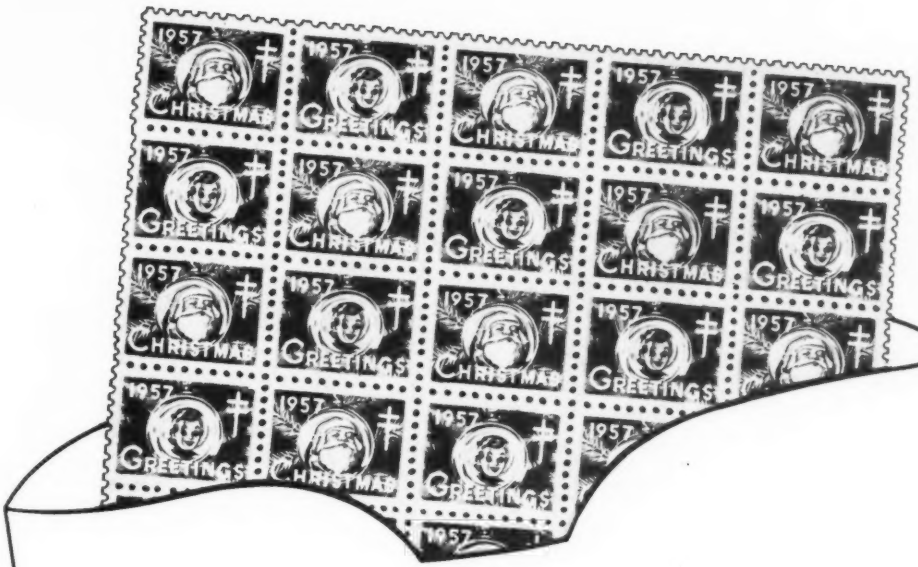
NATIONAL TUBERCULOSIS ASSOCIATION

SEPTEMBER 1957



The 1957 Christmas Seal Sale

EDITORIAL

The Promise of the 1957 Seal Sale

by Clarence W. Kehoe
Director, Christmas Seal Sale Division, National Tuberculosis Association

George P. Ludlam, vice president of the Advertising Council, once wrote when pointing out the reason a particular fund-raising campaign had succeeded, "That reason is the existence of widespread local organized facilities for collecting funds. In our experience this is absolutely critical to the success of any fund-raising appeal using mass media."

The Christmas Seal Sale meets both of the above conditions, since mass media and local organized facilities for collecting funds are very important elements in the over-all campaign. The tuberculosis associations have developed an effective way an individual can contribute to the Christmas Seal Sale—by use of the mail.

Each year the amount raised in the Christmas Seal Sale through the mail increases. In 1948, the amount received by mail was 92 per cent of the $20,153,476.49 final, or $18,541,198.37. In the 1956 Sale, a new all-time high was reached. Based on the figures of the Christmas Seal Study Club, 95.9 per cent of the total was received by mail, or $25,231,760.89 of the final $26,310,491.03.

Certainly, in the 1957 and future Christmas Seal Sales, tuberculosis associations will want to pay special homage to the employees of the post offices who so competently handle the mass mailing of Christmas Seals and the delivery of contributions to the associations. These men and women are in the front lines in the battle against the common enemy—tuberculosis.

The people of this great country and its possessions have emphatically endorsed the method employed by the tuberculosis associations for collecting funds. Each year more and more individuals join the ranks of those who voluntarily contribute to the Christmas Seal Sale. In the 1956 Sale it is estimated that 14 million people made a contribution to support the program activities of the tuberculosis associations. This is a commendable record.

The mail Sale is a low-pressure campaign. It offends no one. It does not exert force to make people contribute. It maintains a "family relationship" between the people in the community and the tuberculosis association. Within the privacy of his home, a person makes his decision to contribute and the amount of his contribution. This is America in action—the individual freedom to make decisions and the individual freedom to take appropriate action.

There are many ways to raise funds. Some organizations use the telethon; others, house-to-house solicitations, personal solicitations, payroll deductions, etc. Each agency should have the right to use whatever legitimate method it thinks best suits its situation. Another feature of the Christmas Seal Sale by mail is that it does not conflict with these methods employed by other agencies, be they independent campaigns or of the federated type. In the Christmas Seal Sale the employer and employee are not bothered at their place of employment. There is no personal solicitation, no neighborhood door-to-door collection.

The Christmas Seal Sale lends itself to the wise and wide use of volunteers. The entire history of this method of campaigning is rich with extensive citizen participation in the actual operation of the Christmas Seal Sale. This army of volunteers who gladly give of their time and effort are really the core of the campaign—the most important part. As plans rapidly progress for the 1957 campaign, a warm salute goes to each member of this army of volunteers who make possible the Christmas Seal Sale.

The prospects are very favorable for a successful 1957 campaign. Economic conditions point to a banner year. Tuberculosis associations have extended their list coverage and upgrading. More Christmas Seals and Bonds will be in the homes of people on the opening date, November 15, than in any previous Sale. Enthusiasm runs high for that great American tradition—the Christmas Seal Sale.

bulletin
NATIONAL TUBERCULOSIS ASSOCIATION

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Why an Independent Seal Sale?

In the Midst of Pressures for Joint Fund Raising, We Might Do Well to Re-examine the Birth, the History, and the Manifold Rewards of the Christmas Seal Sale

by John H. Biddle

Mr. Biddle is publisher of *The Daily News* and president of radio station WHUN, both of Huntingdon, Pa. He is secretary of the Huntingdon County Tuberculosis and Health Society; past president of the Pennsylvania Tuberculosis and Health Society and chairman of its Christmas Seal Sale Sponsoring Committee; and a director of the National Tuberculosis Association. He is a graduate of Haverford College, Pa. His article is sponsored by the Governing Council of the National Conference of Tuberculosis Workers.

The old adage that "nothing succeeds like success" has been particularly true of the voluntary tuberculosis movement. Year by year the constantly expanding programs of the tuberculosis associations attest to that success.

But success did not come about overnight. Our pioneer leaders in the anti-tuberculosis campaign were sometimes voices crying in the wilderness, for they had little to back up their efforts beyond an extremely bony skeleton of an organization plus the dedication of informed men who knew what needed to be done and were determined to do it.

The First Seal Sale

As we embark upon the 51st annual Christmas Seal Sale, we may do well to recall how this remarkably successful fund-raising device first came into being, enabling those pioneers to get the battle against tuberculosis under way.

When Emily Bissell read Jacob Riis's article in *The Outlook* of July, 1907, describing the seal sale conducted by Einar Holbell, in Denmark, she suddenly conceived of a Christmas Seal Sale for the United States.

There could have been no more propitious time of the year than Christmas to stage the first and succeeding Seal Sales. Certainly a good fairy presided at the birth of the United States Christmas Seal Sale.

First and foremost, of course, the Sales over the years have provided the funds with which several thousand associations carry on broad public health programs.

But a point that is almost as important to our tuberculosis societies is that, for the first time in history, a whole people was made aware of a great public health problem.

It is well we remember that the tuberculosis menace is entirely different from many of the other common diseases which now have active control and prevention associations.

I may be the victim of a serious heart disorder, but I am not a public health problem. So far as we know, I cannot infect other people with whom I come in contact.

I may be suffering from a malignant or other organic disease, but again I am no menace to others from the standpoint of infection.

When the first Christmas Seal Sale was launched, the public needed to be reminded dramatically once a year that every person with active tuberculosis was a potential killer of his family, friends, and associates.

This story still needs to be told. And it cannot be told through any Community Chest promotion or "give once for all" slogan. It must be told in the same way that has proved successful for 50 years.

Hope for the Hopeless

When, in later years, Emily Bissell described her small beginning in 1907, she said, "I see thousands who had no hope and who have it now. I see thousands of little children, crippled and sickly, who never had a chance for health and strength before, and millions of school children who are learning to be strong and vigorous all their lives long. I see thousands of doctors and nurses, alert to help and save. I see millions of the great, generous American people, rich and poor, upon whom we can rely to carry the Seal forward year by year.

"I have always seen the Seal this way—in terms of people, not of money; educative and cooperative first, last, and all the time.

"The great need of any social work is to reach enough people and make them understand what is wanted. After that the money comes. It is comparatively easy to get five- and ten-dollar subscriptions. But the real public—the people who can afford to give from ten cents to a dollar—how can you get into contact with them and tell them what it is all about in some way that will enlist their interest and their help? This was always in the back of my mind, but I never found any answer until I read the article by Jacob Riis."

A Symbol of Education

In our fund raising, we are in a fortunate and favorable position. First of all, the Christmas Seal Sale itself is the most important single educational feature of the whole tuberculosis movement. The Seal is a symbol of education, of the joy of giving at Christmastime, of hope for the afflicted, of general gratitude for those who have been given a helping hand.

It may surprise some who have not read it to know that the famous article Riis wrote for the *Outlook* in 1907, which was Emily Bissell's inspiration, included these words on education of the public:

"What I want to know is why we cannot here borrow a leaf from Santa Claus's Danish year-book, and do as they have done. Why should we not have a Christmas Stamp, printed by a Tuberculosis Committee, and sold not for the purpose of building a hospital—let each state or town build its own—but for the purpose of rousing up and educating the people on this most important matter. . . . It is because they do not know a few amazing simple things that people die of tuberculosis."

The second reason that we are in a

fortunate position is that all of the old arguments in favor of Community Chests and federated fund raising simply do not apply to the Seal Sale.

We run a low-pressure campaign. We raise our funds by mail. We do not have to recruit large numbers of solicitors to ring doorbells and go from house to house. We do not have to recruit team captains and endless numbers of solicitors.

The slightly higher cost of raising our funds is more than offset by the educational value of reminding people once a year that tuberculosis still has not been licked, although our goal is now total eradication of this age-old plague.

I think you would all agree with me that if some person or foundation would be willing to contribute the millions of dollars equal to one year's income from the Christmas Seal Sale, we would say, "No, thank you."

The Christmas Seal Sale is part of our way of life. Its educational value is self-evident. That it is a highly successful way of fund raising is shown by the hundreds of attempts to take it over for other causes. But Emily Bissell's tiny piece of paper with its "Merry Christmas," and all its billions of descendants, remain in a paramount position. Their power is demonstrated year after year at the Yuletide season.

No general ever retreated when success was attendant and the goal plainly in sight. Those who would try to persuade us to join in another method of fund raising simply don't know what they're talking about. Let us hold fast to what we know is good and right.

NRA Plans Annual Meeting

The National Rehabilitation Association will hold its annual meeting in Minneapolis, Minn., October 2-4. The theme of the meeting will be "New Horizons in Rehabilitation." The National Tuberculosis Association will participate in a panel on "The Rehabilitation of the Older Worker" and will be represented by Ralph Susman, associate, NTA Rehabilitation Division. Those desiring to attend should write to Thomas F. Mulrooney, Minnesota Tuberculosis and Health Association, 614 Portland Avenue, St. Paul 2, Minn.

Mr. Werle Retires

Mr. Nichols to succeed him as executive in Michigan. Mr. Summers to head Kentucky

Theodore J. Werle, a pioneer leader in the tuberculosis control movement, retired September 1 as executive secretary of the Michigan Tuberculosis Association. Mr. Werle has held this position since 1922. He will become executive secretary emeritus and will continue in that position until May, 1958.

J. Irvin Nichols has been appointed to replace Mr. Werle. Mr. Nichols has been with the Kentucky Tuberculosis Association since 1948 and has been executive secretary since 1951. He holds a B.A. degree in economics from Duke University and an M.P.H. degree from the University of Michigan.

Thomas P. Summers will replace Mr. Nichols as executive secretary of the Kentucky association. He has been with the association since 1950, as a field representative and presently as Seal Sale director. He received an M.A. in health education from Western State College, Ky.

Change In Alaska

Mrs. Frances Paul retires as executive secretary; Miss Szadzewicz to replace her

Mrs. Frances L. Paul has retired as executive director of the Alaska Tuberculosis Association. Mrs. Paul came to Alaska in 1920 and taught elementary grades for the Bureau of Indian Affairs for 15 years.

She was a member of the first group to sponsor a Christmas Seal Sale in Alaska, in 1934, and was one of the incorporators of the Alaska TB association. She served as health education chairman, vice president, and president before becoming executive director in 1949.

Gertrude Szadzewicz will replace Mrs. Paul on September 16. She has been an associate in the Personnel and Training Division of the National Tuberculosis Association since 1955. Prior to this, she was assistant executive secretary of the Hampden County (Mass.) Tuberculosis and Health Association and executive secretary and rehabilitation consultant for the Berkshire County (Mass.) Tuberculosis Association.

For Services Rendered

THE National Tuberculosis Association has devised an award that affiliated associations can present to persons or groups who deserve special recognition—outgoing board members and presidents, retiring volunteer workers, distinguished local citizens. Based on the NTA's 50th Anniversary Medallion, the new award provides space for a personal inscription to the recipient. Both sides are shown above.

Patients and Publicity

The Mother Discharged from a Tuberculosis Hospital in Time to Get Home for Christmas Can Often Do More to "Sell" Our Program Than a Hundred Statistics

by K. W. Grimley

Mr. Grimley has been executive secretary of the Alabama Tuberculosis Association since 1940. From 1924 until 1940, he had been associated with the Jefferson County Board of Health in varying capacities. He worked with the Alabama association on a part-itme basis from 1932 until he became executive secretary. Mr. Grimley graduated from Alabama Polytechnical Institute in 1924 and received his master's degree from Massachusetts Institute of Technology in biology and public health. In 1955-56 he was president of the National Conference of Tuberculosis Workers.

What do you suppose is the mightiest asset of the campaign against tuberculosis? Not some drug with a long name. Not the skill of surgeons. Not even the generosity of the buyers of Christmas Seals, proud though we are of their growing legion. The mightiest asset is the courage and the faith of those who fight tuberculosis as a very personal enemy.

Alas, so often we who have been entrusted with using the assets of the campaign against tuberculosis call these patients statistics, and as for their stories, we run and hide them in the earth of anonymity. Tuberculosis association executives and public relations directors should read again the Parable of the Talents. In this, we servants of a greater master were enjoined to place such coin in the market place, that it might increase.

Stories Are Everywhere

So many ask, bewildered, "How can we get the story of TB across today, with the lowered death rate and the public apathy?" The answer is obvious. All about us are wonderful stories to tell. Stories that *will* compete in the crowded battle for newspaper space and television time. Stories that will stand up to the headlines speculating about the Communists' intentions, the attacks on the Eisenhower budget, the train wreck that injured two people, the sex murder in a distant state, the dog that got caught in the sewer. Right at hand, if we but dig them up, are priceless stories of conflict and courage.

I'm not talking about the stories of Will Ross and Trudeau. Those two immortals would be the very first to tip their hats in salute to the poor Negro tenant farmer in my neighboring rural county, struggling against the boll weevil and the rain to get money for drugs for his son, because my state has yet to appropriate funds for drugs for the nonhospitalized patient. They would be the first to raise a cheer over the story of the Birmingham housewife and mother who got home to her two little girls in time for Christmas. What a story of victory! And it happened just down my street.

Please do not say you cannot find such stories. They are wherever tuberculosis exists. And do not say people will not allow you to use their names. I once thought this, too. The idea is a throwback to the days when tuberculosis was considered a disgrace. If you do not believe times have changed, stir about you and see. And take pride in what you find, for you and all of us have been a part of it. Evidence of the mighty achievement of the tuberculosis movement and of the power of health education is the fact that today most patients and ex-patients are proud of the part they have had in our joint triumph over TB.

In Birmingham each September, our community organizer-public relations director goes out to talk things over with the social worker of our district sanatorium. Since the tuberculosis association in this community operates the mass X-ray service, we're particularly interested in patients whose tuberculosis was first discovered by this program. And of course we're most interested in those about to be discharged or who have recently been. It isn't hard to locate a half-dozen to a dozen such persons.

Getting Cooperation

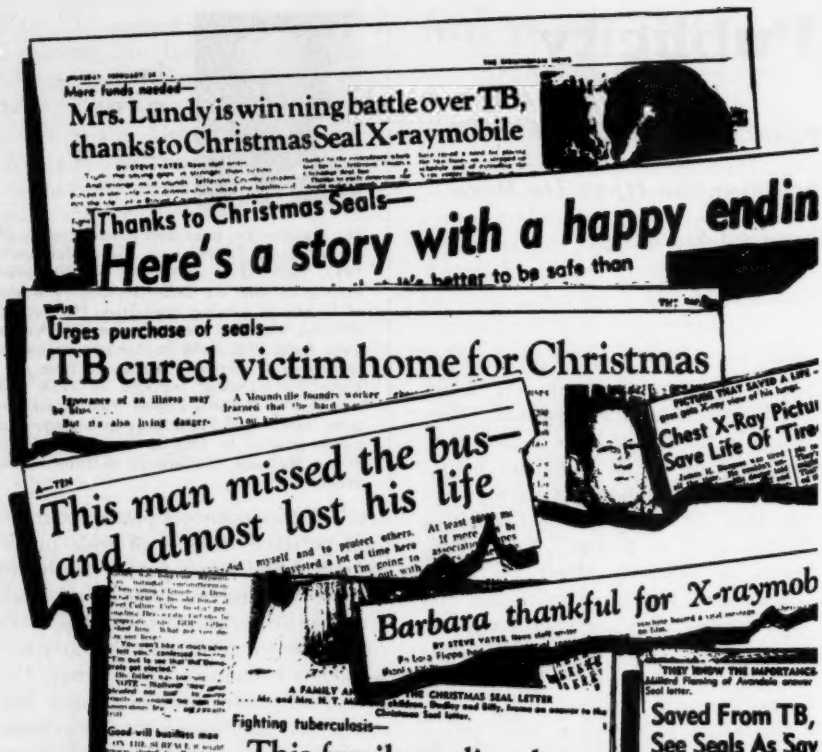
The next, all-important step is to secure the cooperation of the individuals. We are far from being high-pressure salesmen. We just sit down and talk with these patients. Most people like to talk about their "operation." Most people are pleased to think their personal story is of wide public interest. And most people really do want to help others along life's road. "It happened to me; it could happen to you. I overcame it, and so can you." Although I ought to know better, I'm always surprised how very, very few refuse us permission to carry these words to the ends of the earth if we can.

These six to twelve patients are the "shock troops" of our year's publicity campaign. I used the word "publicity." I could have said public relations or education. Why split hairs? Of the six to twelve stories each year, one or two usually turn out to be so dramatic that pinpoint accuracy of definition is as unnecessary as in the case of the hydrogen bomb.

Human Interest Sells Itself

With such material, we haven't found much difficulty in getting it well used. Human interest is the grist upon which grind all the media of mass communication. Each story is usually good for a picture or a picture layout, a headline, and enough copy to carry the message of faith and courage and good will. Last year we were pleased that one of our television outlets thought enough of one of our stories to assign a crew to produce it on film for its own use.

In a program of this kind, we certainly do not believe it is necessary to have prominent, social-register names. Our whole tuberculosis control campaign has always been directed to that family down the street. People are in-


More funds needed—
Mrs. Lundy is win ning battle over TB, thanks to Christmas Seal X-raymobile
Thanks to Christmas Seals—
Here's a story with a happy endin
Urges purchase of seals—
TB cured, victim home for Christmas
This man missed the bus— and almost lost his life
Chest X-Ray Pictu Save Life Of 'Tire
Barbara thankful for X-raymob
Fighting tuberculosis—
This family realizes how Christmas Seals help out
Saved From TB, See Seals As Sav
A foteful step into the Christmas Seal bus—
She was 'scared stiff' until she found you can beat TB in time

TB patients make the headlines in Alabama—as they can anywhere—because stories about the courage and the faith of average people have universal appeal.

terested in people like themselves. We thrill to stories of difficulties faced with resolution and courage, regardless of the color or creed or class of the possessors of the stout hearts.

Some of my more gentle readers may be thinking that this publicity program of ours is strong medicine. There are good people who are very proud that the voluntary tuberculosis movement has always been distinguished by its conservative public relations attitude. (I realize on the other hand that others have gone as far as or much further than we have in dramatizing the real-life impact of tuberculosis.)

Are we "exploiting" these patients? Perhaps, in the sense that all of us have been "exploiting" Trudeau these past 50 years and more. Conversely, we are grateful that in Birmingham we have given many living persons an opportunity to have that glow which comes from knowing that one has provided inspiration for others, about which Trudeau wrote so feelingly in the closing pages of his autobiography.

Perhaps our publicity program is strong medicine, but these are strong times. And as we close to storm the inner citadel of this thousand-year pandemic of tuberculosis, some frank and honest and heroic measures will be necessary. These adjectives do not describe, incidentally, the John Doe approach in case-history publicity. It is insincere and, it seems to me, destructive to the morale of the patient himself to say to him, first, tuberculosis is no disgrace, and, second, let us use your story under a pseudonym. The patient may well begin to wonder whether we are not by implication contributing to the prejudice.

Trudeau wrote of the struggles in which even the gloom of death could not smother the triumphant note. In the want-ad section of our daily newspapers is a section of paid obituary notices, used sometimes by, among others, the families of those too poor and inconsequential to have their passing noted editorially. With varied emotions, I read one last December—published unsolicited by us, I hasten to say. It listed a man's name, with the information that he had died the previous day, of tuberculosis. Then it said—I cannot recall the exact words, but they were approximately—"He wanted us to tell you to be sure to get *your* chest X-ray *in time*." Thus do faith and hope and love for one's fellow men march on.

The vitality of the Christmas Seal, a phenomenon which has perplexed many observers over the years, has sprung from the opportunity it has given to millions of ordinary people to rise above themselves into the greatness of generosity. I like to think our publicity program has given an opportunity to similar people to rise into the greatness of inspiring others to courage and resolution by their example.

X-ray Survey Held at AMA Annual Meeting

The National Tuberculosis Association and its medical section, the American Trudeau Society, in cooperation with the American Medical Association, provided chest X-rays for physicians attending the American Medical Association's annual meeting in New York City, in June. Of 720 X-rays taken, 550 were negative, 40 showed suspected tuberculosis, 34 showed other chest diseases, 30 showed cardiovascular disease, and 66 were technically unsatisfactory.

"Time to Test—How to Give the Tuberculin Test," the new scientific exhibit produced by the NTA and ATS, was shown at the meeting and aroused considerable interest.

11 Public Welfare Needs

by A. Ryrie Koch

Director, Rehabilitation Division
National Tuberculosis Association

Nearly 50 Per Cent of TB Patients or Their Families Need Some Public Assistance. Yet We Often Overlook the Importance of Effective Public Welfare Programs

The medical social worker looked impatiently at the 62-year-old man sitting beside her desk. With an almost perceptible sigh, she said, "Mr. Bohlen, you have been in this hospital just four weeks. You can't go home now. You have far-advanced tuberculosis."

The elderly man answered calmly but firmly, "I know I shouldn't go home. I want to stay here. I belong here until I am cured. But, Miss Martin, my wife doesn't even have food at home. She's been my responsibility for thirty-eight years. I must do something now—today."

Miss Martin asked, "You have no savings she could use?"

Mr. Bohlen carefully pulled his hospital bathrobe more tightly about his thin, angular frame. "Miss Martin, I've supported my wife and myself since the day of our marriage, but we've never had any savings worth mentioning. The little we did have went for doctor and hospital bills when Mary, my wife, was sick last year. When I learned I had tuberculosis and couldn't work again for at least a year, I went to our welfare department and told them the whole story. They promised they would come see Mary and help her right away. I just had a letter from Mary this morning, and she says she called them last week, when things got really short, but they still haven't come to see her." Mr. Bohlen rose with obvious effort from his chair. "Miss Martin, I'm sorry, but I have to go home today. I'll be back if I can straighten things out."

In tuberculosis control, we emphasize strongly the responsibility of private physicians, hospitals, health departments, and state vocational rehabilitation agencies. We tend, too frequently, to forget the important role of state and local departments of public welfare or whatever agency is responsible for administering the several public assistance programs.

It is not generally realized that nearly 50 per cent of tuberculosis patients or their families in this country are forced to apply for public financial aid sometime during the course of this long, costly illness.

Recently, the California Tuberculosis and Health Association completed a rehabilitation study which included approximately 500 men with active tuberculosis or whose tuberculosis had been "arrested" two years or less. Seventy-four per cent of these men were found to be dependent, partially or totally, on some other person or agency. Too many public welfare departments are not aware that their administrative practices (or lack of them) sometimes significantly retard development of the most effective tuberculosis control program. Mr. Bohlen's story bears this out.

Public welfare departments should therefore carefully consider the following 11 points in making policy and defining practice and procedures for their casework staff.

Provide Social Service. "What do I tell my employer?" "What will happen to my children?" "Who will support my family while I'm in the hospital?" The diagnosis of tuberculosis comes as a shock, a blow, for many patients. Such questions are normal and understandable. Medical social caseworkers in clinics do much to relieve the fears and anxieties of patients by helping them find answers to these questions, but only *some* of the clinics in *some* of our large cities have caseworkers. According to a Public Health Service survey, 80 per cent of the rural tuberculosis population have no casework service available other than financial assistance provided by departments of public welfare. Upon diagnosis of tuberculosis, most patients discontinue work and enter a tuberculosis hospital. Their families frequently have to apply for some financial help. Departments of welfare must be ready to reassure these families, allay their fears, and maintain a liaison with the social service departments of the tuberculosis hospitals where patients are being treated.

Grant Assistance Promptly. Since tuberculosis is an infectious, communicable disease, the patient should be isolated as quickly as possible. A man will rarely accept hospitalization unless he knows that plans have been completed for the financial support of his wife and children. A woman patient will not go to a hospital unless she knows that her children will have care during her absence. Therefore, public assistance agencies have a tuberculosis control responsibility—to investigate and grant assistance quickly. Placing the family of a new tuberculosis patient on a waiting list or compelling them to await results of a long, drawn-out or delayed investigation for general assistance, aid to the permanently and totally disabled, or aid to dependent children only encourages a patient to delay his hospitalization. Practices and procedures for public assistance application should be geared to patient and family needs, not to the convenience of administration.

Provide Incidental Needs. Financially dependent patients frequently leave hospitals against medical advice because they are without funds to purchase incidentals necessary to their daily living. Inability to buy toothpaste, a toothbrush, writing paper, postage stamps, tobacco, and even pajamas violates the dignity of a patient in a ward where other patients are able to buy these items. Incidentals essential to long-term hospitalization should be included in determining amounts of assistance payments. Also, an item for transportation costs of the patient's family to make periodic visits to the hospital should be considered.

Prompt Payment on Discharge. Most patients, upon discharge from the hospital, are cautioned by the physician to continue rest and treatment at home.

For a period of months they will not be able to work. Some, therefore, will be dependent upon public assistance. During this period of convalescence, home conditions should be such that nutrition is adequate and that recovery is not retarded by unnecessary anxiety and concern about financial support. If at all possible, departments of welfare should establish a procedure whereby a patient can apply for public assistance prior to hospital discharge, so that the application can be investigated in time for the first assistant payment to be issued concurrent with discharge. In several areas, caseworkers from departments of public welfare call regularly at county and state tuberculosis hospitals to accept applications for assistance from those patients in financial need expecting discharge within several weeks.

Help Unattached Patients. It is unfortunate that so many "unattached" patients leaving hospitals are viewed with doubts about their personal stability and character. Quite often they will be refused assistance simply because they are unattached. If assistance is granted, it is given in an amount which enables them to rent living quarters only on skid row. The skid row districts of our various large cities are known to harbor and breed tuberculosis. Every possible effort should be made by public assistance agencies to avoid placing unattached persons in such an environment.

Provide Transportation to Clinic. During home convalescence after hospital discharge, many patients are required to report monthly to clinics for continued treatment and observation. Without funds for transportation to clinics, which in some states are as many as 100 miles away, treatment may be discontinued. In the Public Health Service survey it was found that one-sixth of all patients in the study sample were under no medical supervision at all! It is quite possible that some of these patients neglected or discontinued their treatment in clinics simply because they did not have funds for transportation. If this item of necessity is not considered by a public assistance agency in determining the financial need of a tuberculosis patient, a community's tuberculosis control program may be retarded.

Good Housing Standards. Because of the public's fear of tuberculosis, patients discharged from hospitals frequently encounter real difficulty in finding acceptable living quarters. Yet, public assistance agencies frequently refuse to grant assistance to a patient who has no address. These agencies, in cooperation with tuberculosis associations and other community agencies, should establish a register of *approved* rooms or apartments that will be readily available to tuberculosis patients upon hospital discharge.

Refer for Vocational Rehabilitation. The vocational rehabilitation potential of all patients receiving public assistance should be carefully determined. In every instance where the physician indicates that the patient may someday return to work, that patient should be referred to the state vocational rehabilitation agency and the state employment service. At least half of all tuberculosis patients today are over 45 years of age and have difficulty in securing jobs. For this reason, public assistance and state vocational rehabilitation agencies, and the employment service, should have a plan for rehabilitation of these clients so that they may find suitable jobs when their physicians declare them ready for employment.

The 1958 NTA, ATS, and NCTW Annual Meetings will be held in Philadelphia, Pa., May 18-23. Full information about hotel reservations will appear in the November *Bulletin*.

Will anyone who has ideas or materials for exhibits, movies, or TV programs please write to Dr. E. Wayne Marshall, chairman, 1958 Exhibits Subcommittee, 1520 Spruce St., Philadelphia 2, Pa.

Recheck Clinical Status. Reports from physicians at the time a patient applies for public assistance frequently indicate that the patient is still under treatment and does not have sufficient work tolerance *at this time* to undertake employment. However, this is a temporary condition. Periodically, the agency should recheck the patient's activity status with the physician to determine when he is ready for work. Surveys of public assistance rolls have revealed many patients kept on assistance long after they were able to accept jobs, simply because no procedure was established to recheck periodically their readiness for work.

Assist Nonresident. A serious problem is presented today by those states with laws denying assistance to nonresidents of the state. The concentration of tuberculosis is known to be largest among low-income families in poor housing areas. It is in such areas that many nonresidents reside. If a nonresident is found to have tuberculosis and public assistance policies do not permit care of his family during treatment, that policy invites the transmission of his infection to other family members and all other persons with whom he may have contact. Residence and local settlement laws and regulations frequently work hardships on the tuberculous. Care of the tuberculosis patient and his family should be provided as a public health measure, regardless of residence status.

X-ray Older Recipients. Most tuberculosis today is found among our older population, particularly among men over 45. It is therefore just good economy for any public assistance agency to see that its older public assistance recipients are X-rayed. A case-finding program for older clients should be worked out with the health department and the tuberculosis association.

In the Public Health Service survey of nonhospitalized patients, it was found that of all patients previously hospitalized, 45 per cent had left the hospital against medical advice. This is extremely significant in relation to the administration of public assistance. Unless patients are sure that their families are cared for at home during their absence, they will not be satisfied to remain in the hospital. Tuberculosis control in any community is a program for which a department of public welfare has responsibility, almost as much responsibility as a department of health.

Friendly Persuasion

Training, Plus Understanding, Makes the Medical Social Work Consultant a Valuable Member of the Public Health Team in Reducing the Number of Uncooperative Patients

by Caroline H. Elledge

Mrs. Elledge is chief social work consultant for the New York City Department of Health. Formerly, she was a member of the faculty of the School of Social Work, University of Denver. While there, she also served as civilian consultant on social work to the Fitzsimons Army Hospital, a major army facility for treating tuberculosis patients. She is the author of a book *Rehabilitation of the Patient*, and holds an M.A. from the Graduate School of Social Service Administration, University of Chicago. Her article is sponsored by the Governing Council of the National Conference of Tuberculosis Workers.

For many years, the tuberculosis control program of the New York City Department of Health has included the maintenance of chest clinics in local health districts where both medical and public health nursing services are available to tuberculosis patients and their families. Two years ago, medical social work consultants were added to this program.

To further explain the program, perhaps we should remind ourselves that the functions of the public health nurse include helping a patient to accept hospitalization and exploring with the family their over-all social needs, with the offer of referral to appropriate community agencies as necessary. Cooperative planning with representatives of other community agencies on behalf of families is an accepted part of their daily work.

Not a Substitute

The medical social work consultants are neither a replacement for nor an alternative to the public health nurses. Rather, their contribution is made on the basis of their professional competence and experience in medical social work. They are prepared to offer consultation to staff and provide short-term casework services in the most difficult situations. Their participation in district services enhances cooperative planning with social agencies. While referrals are made to them from any source, within or outside the Department of Health, the medical social work consultants always clarify the situation with the supervising public health nurse before taking action, to avoid duplication of effort and to preserve the public-health-team approach in helping patients and their families.

In regard to the uncooperative patient, the Department of Health, through its Bureau of Tuberculosis, has the legal power to "force in" any person considered a "public health menace." A small number of prison hospital beds are available for this purpose. The procedure is relatively simple: Upon sufficient evidence, the director of the Bureau of Tuberculosis may order the police to "pick up" a tuberculosis patient and take him, by force, to the prison hospital.

Fortunately, the Department's philosophy is such that this procedure is used only after all other efforts to gain the patient's cooperation have been exhausted. It is the Department's firm conviction that the best interests of the individual and the community are served when a maximum effort is made to gain the patient's cooperation. Frightening people with the threat of a force-in does not enhance the long-range goals of tuberculosis control.

To avoid giving the impression that the medical social work consultant has a magic touch in every situation, following are the results of a sample case count which was taken in four different health districts, with a total of 53 cases: 32 patients accepted hospitalization and remained cooperative during the entire period; five accepted hospitalization but left against advice in less than four months (all five are now attending clinic regularly); eight could not be persuaded to accept hospitalization, but for a combination of medical and social reasons, the physician permitted them to remain at home and all are still attending clinic regularly; four became "force-ins"; three were lost; and one is under the care of a private physician.

It is gratifying to note that the medical social work consultants were able to gain the full cooperation of 70 per cent of this hard-core group who had not responded to the physician's or nurse's efforts in the medical plan of choice, hospitalization. In addition, their contribution of understanding the patients and helping them to respond to the need for medical care and supervision was probably a major factor in inducing some others to accept the physician's second choice, clinic care. Thus, of the 53, only seven, or 13 per cent, were considered entirely "uncooperative."

Getting the Whole Story

Perhaps some illustrations may be helpful. An intelligent white-collar worker's tuberculosis was discovered during a routine health examination which included a chest X-ray. When originally told of his diagnosis, he became resentful and inaccessible to reason. The clinic physician and the public health nurse tried unsuccessfully to gain his cooperation.

When the medical social work consultant talked with him, she learned that the man had a new job, which he had wanted for a long time. He saw the Department of Health as a monster swooping down and snatching this job away from him. He had been too polite to let loose like this when talking with the clinic physician and public health nurse. Why did he do it when the medical social work consultant visited him? We believe that the medical social workers' intensive professional training and experience in working continuously with people in serious trouble enables them to get the less accessible client to communicate his feelings.

Once this man's resentment and

frustration were fully expressed, he was then ready to consider the reasonable approach, to discuss his illness with the chest physician, and to accept hospitalization. The medical social work consultant found out how he could secure a leave of absence from his work, and the public health nurse gained his family's cooperation in contact examinations.

Dealing with Fear

In another case, a young factory worker who was X-rayed as a part of a mass survey fled in fear when the recall center asked him to return. Friends said that the "letter" meant hospitalization if he appeared. The public health nurses' visits to the home were fruitless. The family said he had "left" home.

Since his parents and several younger brothers and sisters were receiving supplementary public assistance, the District Public Welfare Office knew his place of employment. The medical social work consultant was able to convince him over the telephone that the Department of Health wanted to help him get well. He accepted and kept an appointment at chest clinic.

When hospital care was recommended, the social worker in the hospital was added to the cooperating team. A case conference was held with all the agencies interested in the patient and his family. Again, contact examinations were successfully carried out. During hospitalization, the social worker there helped him accept his illness and the need for care. He remained for five months, and his condition was so improved that he was permitted to continue treatment in clinic, even though he went home sooner than the doctor would have desired.

What made it possible to gain this young man's cooperation without the moral support of either his family or neighborhood friends? First, he was given consideration as a person who was frightened, underprivileged, and confused. The chest clinic doctor and nurse, as well as the medical social work consultant, showed patience and understanding. They gave him the support to accept hospitalization. When he was hospitalized, the social worker there contacted him immediately.

This patient is now an ambassador of good will for the Department of Health, rather than an obstructionist. Shortly before this paper was written, he brought to clinic a friend who was coughing and felt sick. He introduced his friend to the medical social work consultant and said, "This fellow is scared—like I was." His friend does have tuberculosis and will be hospitalized. If the experience of the first young man had been one in which he linked up "X-rays—chest clinic—police—prison hospital," his advice to his friend would probably have been "Stay away from those X-ray machines."

A Failure

It would be unfair to use only successful case illustrations. The following is an example of complete failure in the total team effort:

A 38-year-old man, acutely ill and with a positive sputum, had been in and out of several hospitals during a four-year period. He returned to his wife and five children, who lived in a one-room tenement. His wife had long since "discarded" him because of her interest in other men. He displayed his contempt for his family not only with abusiveness but also through careless handling of his sputum. The children had many social problems, and a referral to a children's agency was necessary.

Many conferences were held between the health center staff, the children's agency, and the hospital social service departments who knew various members of the family. The man was resentful and hostile toward the doctor and nurses, and refused to talk with the medical social work consultant when she visited.

This family's many social problems must have been as apparent in 1952 as they were in 1956. It is unfortunate that the situation had to wait so long for decisive community planning on behalf of the children. If the father's uncooperative attitude toward his disease could have been seen earlier as one symptom of family breakdown, perhaps the oldest child (now 14) would have received the help she needed from a children's agency and might not now be an unmarried mother.

To summarize, the use of a medical social work consultant in a tuberculosis program is of value to patients, their families, and the community both in terms of rehabilitation and in control of the disease. To gain cooperation from a majority of patients referred as "hard-core cases" is as much as one could hope to expect. Beyond the capacity of a medical social work consultant are those few patients with such severely disturbed behavior that only a psychiatrist could determine their potentialities for cooperation.

Mr. Koch Resigns

NTA Rehabilitation director to join the Boston Office of Vocational Rehabilitation

A. Ryrie Koch, director of the Rehabilitation Division of the National Tuberculosis Association since 1954, has resigned effective September 1 to become a regional representative for the Office of Vocational Rehabilitation, in Boston.

Mr. Koch has been responsible for planning the NTA's national efforts to stimulate and develop effective rehabilitation programs for tuberculosis patients among state and local tuberculosis associations. Prior to joining the NTA, he was an associate regional representative with the U.S. Bureau of Public Assistance and a regional representative of the Office of Vocational Rehabilitation.

Mr. Gerard Resigns

Wyoming executive joins Division of Indian Health as tribal relations officer

On August 15, Forrest J. Gerard resigned as executive secretary of the Wyoming Tuberculosis and Health Association to become tribal relations officer with the Division of Indian Health, U.S. Public Health Service, in Washington, D.C.

Mr. Gerard joined the Montana Tuberculosis Association as a field consultant in 1953, and became executive secretary of the Wyoming association in 1955. He holds a B.A. in business administration from Montana State University.

Increased Funds for the PHS Tuberculosis Program's Isoniazid Study and a Cutback for the Indian Health Division Were Among the Provisions of the . . .

1958 PHS Budget

The United States Congress has appropriated $7 million for fiscal 1958 for the Tuberculosis Program of the U. S. Public Health Service, Department of Health, Education, and Welfare, and $17.4 million for the National Institute of Allergy and Infectious Diseases, which makes the largest single contribution of funds for tuberculosis research.

Of the $7 million voted for the Tuberculosis Program, $4.5 million will be available for grants to states for the direct expenses of prevention and case-finding projects, to be matched by equal amounts of state and local funds. The remaining $2.5 million will be used for cooperative applied research, technical assistance to states, and administration.

Increase for Isoniazid Study

The $7 million budget is $340,000 higher than last year's. Part of the additional funds are due to mandatory civil service increases; the remainder will be used to expand the isoniazid study begun last year to find out (1) if isoniazid can prevent new infections and (2) if it can prevent the breakdown of old infections.

The answers to these two problems—preventing new infections and the breakdown of old infections—are the foremost goals of tuberculosis control today, Dr. Edward T. Blomquist, chief of the program, told the Senate's subcommittee of the Committee on Appropriations.

The first phase of the isoniazid study, Dr. Blomquist said, is to find out whether isoniazid can prevent infection and the appearance of clinical disease among the highly exposed household contacts of active tuberculosis cases. Households are being randomly assigned to isoniazid or placebo groups and kept under close observation by their local health departments. Each contact is tuberculin tested and X-rayed at the beginning and the end of a year of prophylaxis.

The PHS also plans to study isoniazid's effect among previously infected persons who are not in highly exposed situations.

Other research studies include the use of isoniazid as a preventive of tuberculosis meningitis and other complications in children, and investigation of other new drugs, including pyrazinamide.

Dr. Blomquist also stressed the need to strengthen local programs for dealing with the nonhospitalized patient. Recent studies show that no significant improvement has taken place since 1954, when a PHS study revealed that almost half the tuberculosis caseload was outside the hospital.

NTA Statement

The National Tuberculosis Association supported the PHS's request for increased funds. In presenting the NTA's statement before the subcommittee, Dr. Joseph Stocklen, who has represented the NTA Board of Directors before Congressional committees for the past several years, emphasized that the improvement in the tuberculosis picture had been significantly affected by past appropriations to the PHS's Tuberculosis Program. He also said that "state and local voluntary tuberculosis associations are being encouraged to join with the Federal Government in this [the isoniazid] research activity in another example of joint effort similar to those which have been so successful in the past."

In advocating the increased appropriation for the National Institute of Allergy and Infectious Diseases over last year's $13,496,000, Dr. Stocklen pointed out that almost $1 million was being spent this year by the institute on research concerning the tubercle bacillus, pulmonary function, and a more effective vaccine than now available—all of vital importance in the battle against tuberculosis. Many of these projects, Dr. Stocklen said, are also supported by research grants from the NTA.

Indian Program Cut

The Division of Indian Health, PHS, did not fare so well as the other two agencies. Although both the PHS and the NTA had requested $43,990,000 for Indian Health Activities (the program phase), only $40.1 million was voted. While this is an increase of $1,325,000 over 1957, it will mean an actual decrease of about $400,000, because the operating level of the division had reached $40.5 million for year-round programing through a carefully planned increase in activity during 1956-1957. This was due to a necessarily slow progression from a 1956 fiscal appropriation of approximately $33 million to the 1957 appropriation of $38,775,000.

In his appeal for increased funds for Indian Health Activities, Dr. Stocklen told the subcommittee that a high of $60 to $65 million annually will be needed to alleviate the "deplorable conditions" of the Indian and to "remove this disgraceful situation from the American scene." Any cut in the appropriation requested, he said, would not be an "economical procedure, with its resultant loss of lives and well-being and precious time through interruption of carefully planned acceleration."

The NTA did concur with the decision of Congress not to appropriate the additional $2,704,000 requested by the PHS to the $3,096,000 voted for Construction of Indian Health Facilities. The NTA shared the concern of both House and Senate appropriation committees about the lack of progress made by the PHS in this area. Almost $12 million previously appropriated has not yet been spent; until it has been, the NTA agreed that no further monies be granted to this part of the program.

What People Say About TB . . .

What would people say about the current status of tuberculosis if they were asked? During recent years, tuberculosis control workers have been aware that many people believe the disease is practically wiped out. To gauge the extent of this misconception, the National Tuberculosis Association had Audience Research, Inc. (Gallup) conduct a nation-wide poll to determine just what Americans are saying about the tuberculosis problem.

Almost 2,000 people over 21 years old in approximately 200 communities were interviewed in their homes. Each one was asked, "How much progress would you say has been made in overcoming tuberculosis?" Each was then given a choice of four answers: "It has been practically wiped out"; "Much progress has been made"; "Little progress has been made"; "No progress has been made."

Because this group was a carefully selected cross section of the adult U.S. population, their answers can be taken as a rough measurement of what the 100 million Americans over 21 would have said if the same question had been put to them.

What were the results? Six per cent said that tuberculosis has been practically wiped out, 75 per cent that much progress has been made, 15 per cent that little progress has been made, one per cent that no progress has been made, and 3 per cent had no opinion.

Before discussing these findings, a few points should be made about a public opinion poll.

This type of poll does not determine the soundness of an individual's knowledge, the strength of the convictions behind his opinion, or the exact shade of meaning of each person's answer. However, the men and women interviewed had a clear-cut choice of answers, so their answers can be accepted as what they would say when questioned.

Who Said What?

All the answers were tabulated and analyzed to determine if there were significant differences in responses according to age, sex, race, educational attainment, occupation of head of household, economic group, size of community, and region of country. Following are some of the highlights.

The opinion that tuberculosis is practically wiped out, expressed by 6 per cent of the persons interviewed, was scattered more evenly among all classifications than any other opinion except "no progress." Thus, it is presumably held by some persons in the groups from which come today's and tomorrow's community leaders. This opinion is also held by about the same percentage of persons in groups where the prevalence of tuberculosis is high as in groups where it is low.

The Majority Opinion

"Much progress" is, of course, the correct answer, and obviously a clear majority—75 per cent—hold this opinion. But it should be emphasized that some of the people who gave this answer may believe the progress is greater—perhaps far greater—than it actually is. An opinion of "much progress" can change to "practically wiped out" for many reasons, and the change can occur before it is justified.

This opinion was held by a higher percentage of people who were under 50, had had more formal education, were not doing manual labor, had higher incomes, lived in the Midwest and West.

Seemingly, then, the opinion "much progress" is more widely held in the groups where the prevalence of tuberculosis is low. Also it is more widely held in the groups that will provide the majority of today's and tomorrow's community leaders.

The opinion that little progress has been made was expressed by a larger proportion of persons who were over 50, had only grammar school education, were doing manual work, were in the lower economic groups, lived in communities of 2,500 to 50,000 persons, lived in the South.

It is evident that this opinion is more widely held in groups where the prevalence of TB is high.

The one per cent who said "no progress" were found in all classifications except that of college education.

The people who said that tuberculosis has been practically wiped out or that much progress has been made were asked why they believed this had come about. Many people gave several reasons, and 8 per cent had no opinion. The percentage of persons giving answers in the seven main categories were: improved treatment, 41 per cent; better detection, 41 per cent; research—medical science, 26 per cent; more money given, 6 per cent; higher living standards, 4 per cent; food laws, 3 per cent; TB associations—Christmas Seals, 2 per cent.

The answers classed as "improved treatment" included drugs, medicine, new drugs, miracle drugs, new antibiotics, hospitalization, treatment, techniques, medical care, surgery. About half of the 41 per cent who answered in terms of treatment specifically said drugs, new drugs, miracle drugs, and new antibiotics.

The 41 per cent whose answers were classified as "better detection" said diagnosis, tests, clinics, mobile units, X-ray, as well as better detection.

With 41 per cent answering in terms of improved treatment and 41 per cent in terms of better detection, it is apparent that local case-finding activities, backed by local education and public information programs, have made as great an impact on the American people as has the dramatic news of the past decade about improved treatment.

In addition, since only about half of those answering in terms of treatment specifically mentioned drugs, it appears that local case-finding activities have made a deeper impression upon more people than the new drugs.

This poll indicates that millions of Americans have misconceptions about tuberculosis and tuberculosis control. Many of these millions are persons of leadership caliber—the molders of public opinion. Clearly, tuberculosis associations face a vital educational challenge, particularly among this group of community leaders.

Are You POSITIVE?

Look at the top hat worn by the gentleman in the upper-right-hand corner of this page. Anyone can see that the height of the hat is greater than the width of the brim. . . .

But are you positive?

Being positive is the easiest thing in the world. We see things through the special lens of our own needs, wishes, and interests. We see the things we want to see. And we also tend to see and believe what other people around us see and believe.

The Gallup Poll (see opposite page) has shown that of 100 million Americans over 21, at least 6 per cent apparently believe that TB is practically wiped out. Another 75 per cent appear to believe that much progress has been made in combating it, 15 per cent that little progress has been made, and one per cent that no progress has been made.

Clearly this poll indicates that there are widespread misconceptions among millions of Americans about the extent of tuberculosis and the present state of its control.

"Are You Positive?" is a new animated, full-color film that will spearhead an intensive campaign by the National Tuberculosis Association and its affiliates to combat this dangerous public misunderstanding.

After exploding several common misconceptions—a cat can see in the dark, a drowning man rises to the surface three times, the relative height and width of the top hat shown above (have you measured it?)—the film turns to some familiar ideas about TB:

"Tuberculosis isn't a serious problem. You don't hear much about TB deaths any more."

"It's easy to cure TB with all the new drugs that have come out."

"I heard they closed another TB hospital. It just shows they aren't needed."

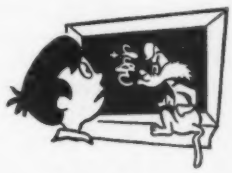
"From what I hear you can get as good treatment at home as in a hospital."

"TB can't hit me—I'm too old."

"But I feel fine. If I had TB, I'd know it from the symptoms."

One by one these familiar beliefs are stated, examined, and then exploded by the narrator with the aid of a group of humorous, professionally drawn cartoon characters. In 13½ minutes, a great many people can potentially unlearn many of their mistaken beliefs about tuberculosis—and be highly entertained at the same time.

The film, of course, is only a rallying point for the over-all, continuing



campaign which tuberculosis associations hope will achieve several aims:

To correct some misunderstandings in the minds of the public about TB control, and thus to forestall any premature tendency to write off tuberculosis as a problem.

To reach, stimulate the thinking of, and improve relations with community leaders, including mass media people.

To generally step up the present programs of tuberculosis associations for the information and education of the people they serve.

The over-all campaign will consist of both a national and a state and local plan to reach and influence the molders of public opinion.

The national plan got under way on August 1 in New York City when "Are You Positive?" was shown to national mass media people. Spokesmen for the NTA, the U.S. Public Health Service, and Audience Research, Inc., all participated in presenting the facts about

tuberculosis and their implications for the entire nation. A full report on this meeting will appear in the October BULLETIN.

A showing of the film for the executives and staffs of national health agencies, citizen groups, and others interested in public health will be held in New York on September 5, and will also be reported in the BULLETIN.

In addition, the film will be shown at the four regional conferences of the tuberculosis associations during September and October.

As state and local efforts to correct misconceptions about tuberculosis get under way, they, too, will be reported upon in future issues of the BULLETIN.

The tuberculosis control movement faces a vital educational and public relations challenge, now and in the months and years ahead. If a nationwide, unified effort is made by national, state, and local tuberculosis associations, unquestionably public opinion can be held in line with the facts.

For 21 Years, Among Students, Parents, Newspaper People, Health Officials, Teachers, the School Press Project Has Spread in Ever-Widening . . .

Circles of Influence

by Col. Joseph M. Murphy and Dorothea Lindsey

Col. Murphy is director of the Columbia Scholastic Press Association. Mrs. Lindsey is an associate in the Public Relations Division of the National Tuberculosis Association.

Back in 1945, when the School Press Project was a mere child, a leading American editor and Pulitzer Prize winner summed it up in two words: "informative enthusiasm."

Commenting further on his experience as a Project judge, Dr. Douglas S. Freeman said, "It makes one exceedingly humble when such young intellects can delve into the weaknesses of our national life. . . . Because of them—and people like them—many of America's problems, such as tuberculosis, will not be problems in our nation's tomorrow."

A Fresh Challenge

The School Press Project comes of age this year, but the "informative enthusiasm" generated in its youth has not faded. We have seen it grow and develop from a contest that was little more than a publicity device to a sound educational project of nation-wide proportions. To each year's new generation of students, it is a fresh challenge. One has only to read a few of their entries to be impressed by the eagerness with which they grasp the opportunity to report on an important community health problem.

Take the *Leslie Broadcaster,* of Salem, Ore., as a random sample of national winners in the 1956 Project. The paper contained a feature story on the day's work of the school nurse, an interview with the head of the county health department on why he chose to make his career in public health, another with the superintendent of the tuberculosis hospital on the current status of the disease, a feature story on a TB patient, a lively editorial on the importance of good health habits to teen-agers, and photographs of staff reporters gathering their materials.

This is by no means an unusual example of the way school reporters will be tackling the 21st annual Project this fall.

It all began with a few Christmas Seals pasted on school publications entered in the Columbia Scholastic Press Association's annual contest. CSPA called these to the NTA's attention, and an idea was born. In May, 1937, CSPA's official publication, *The School Press Review,* announced that the two organizations were working on plans to encourage school journalists to write news and feature stories and editorials on the Christmas Seal program. A similar announcement appeared in the June NTA NEWS LETTER. By late October, plans were completed and the rules announced. Local tuberculosis associations were urged to invite elementary school and junior and senior high school papers to enter the contest by publishing articles on the school's participation in the Christmas Seal program or on some phase of the general tuberculosis program.

Schools in ten states submitted entries, and the NTA selected nine winners. These were exhibited at the annual CSPA convention in 1938 and at the NTA Annual Meeting.

From this modest—even nameless—beginning has developed the School Press Project of today, involving over a thousand school publications. Certificates of Honor awarded by the national sponsors this year were hung on the walls of 124 schools in 32 states, the District of Columbia, and Hawaii. The certificate states that it is awarded "for upholding the highest standards of school journalism through active participation in the community effort to control tuberculosis"—and it means what it says.

Ingredients for Success

Certificates are not won by little essays digesting the facts in NTA pamphlets on tuberculosis, or by editorials urging students to buy Christmas Seals. They are not won even by papers printing a half-dozen lengthy articles showing considerable library research. They are won by papers that have covered the assigned subjects by journalistic methods; that have investigated, reported, and interpreted tuberculosis and health in a variety of ways to interest and influence high school readers. The emphasis is on the cooperative work of the staff rather than on individual achievement.

Award-winning papers don't just happen. Leading journalism educators who have served as Press Project judges tell us they know immediately whether or not the young reporters have been outside the ivy-covered walls. There is internal evidence that they have seen community TB control facilities, interviewed public health officials, talked to patients and former patients, learned the facts about the disease at first hand.

Commenting on the importance of such experiences, William S. Twitchell, Essex County (N.J.) Superintendent of Schools, said, "One of our goals is to encourage interest in serious public problems and provide for intelligent participation in their solution on the part of our pupils. The Press Project admirably serves these purposes."

Making the Most of It

The fact that such a sound educational opportunity is being offered by the Project should be well understood by school administrators and faculty. Dr. Sigmund J. Sluszka, president of the Columbia Scholastic Press Advisers Association, recommends that advisers of school publications sit down with the tuberculosis association to plan details of the local Project.

Careful advance planning by representatives of all groups which will be involved in carrying out the Project will help insure it a warm welcome by the school, the students, and the local press.

Additional prestige and publicity

may be secured by having the local Project cosponsored by the local newspaper. Another added attraction is the offering of local and state awards. In Baton Rouge, La., the two daily papers offer a silver cup for the best entry in the area. The state association awards a cup to the best entry in the state. New Jersey honors a famous son, who died of tuberculosis, with its Stephen Crane awards to the best nine papers in the state.

Keep Standards Uniform

The sponsors have no desire to lay down the law, but they do suggest that it is only fair to schools invited to participate that they be given full opportunity to win national honors. If the Project is presented to students as an "essay contest," it is not likely that the entry submitted will fulfill the requirements for a Certificate of Honor. If local and state awards are not based on the same standards as national awards, confusion is compounded. If young reporters have not been given the opportunity and impetus to go, see, hear, it is not likely that their entry will stack up with entries from other areas.

Four main points have been suggested by the national judges to be kept in mind by the group planning the local Project: 1. Educational value from the point of view of the schools and the association. 2. Interest and incentive for students. 3. Opportunity for them to practice journalistic skills. 4. News interest for the commercial press. They advise at least one "special event" as a kickoff to arouse the enthusiasm of students—and, not incidentally, give them the basis for at least one news story.

Who are these youngsters who work on school papers? They're the bright ones, the ones who are going places. Perhaps only a few will actually go into the newspaper business, but some will, and others will be teachers, business and professional men and women—leading citizens in their communities. The future of tuberculosis control may well depend on their attitudes.

The Los Angeles Project

The students who work actively on the Project are, of course, the ones most deeply influenced by it. But they aren't the only ones. As an example of how widely the circles of influence spread when you drop the School Press Project into the community, take the Los Angeles association's Project in 1956.

To a mass press conference came 800 students and their journalism teachers and advisers. They heard a well-known TV newscaster talk on the area's health problems. They heard a panel of editors and publishers discuss the role of the press in the community's health. They saw exhibits of leading health professions and health organizations.

This was just the kickoff. Back in their own communities, the students planned and carried out interviews and investigations of TB control and on the career opportunities in the health field. Later, schoolmates, teachers, and parents read the lively results. Local newspaper people, health officials, and teachers also read them carefully in order to judge them. Again at the state level, a similar group was involved in judging. (Some of the national judges have commented on how much their full-day stint of reading Project entries has changed their attitudes on tuberculosis.)

From time to time during the months from October through December, the general public of Los Angeles read about the Project in the commercial press. They read about it again when the country's national award winners were announced.

This was, of course, a "big city" Project, but it has its smaller counterparts in counties all across the country. The circles of influence spread and meet to form a nation-wide network of citizens and future citizens who have been affected by the School Press Project.

There is still plenty of room for improvement and expansion. Future development of the Project—as its progress to this point—rests largely on the efforts of the local tuberculosis association. By planning activities to give school journalists the impetus and opportunity to participate effectively, the association can generate that "informative enthusiasm" through which the School Press Project can make an even greater contribution to the ultimate defeat of tuberculosis than it has during the past 20 years.

Books

NATIONAL TUBERCULOSIS ASSOCIATION 1904-1954

by Richard Harrison Shryock. Hard cover, 309 pages with bibliography and index. Published by National Tuberculosis Association, New York, 1957. Price, $3.50.

At the request of the NTA, Dr. Shryock, W. H. Welch Professor of History of Medicine and director of the Institute of History of Medicine, Johns Hopkins University, has presented his own interpretation of the first half century in the organized battle against tuberculosis. He has performed his task with notable insight and understanding.

It is doubtful if there can be found anywhere a more informative or interesting description of the advancement of medical knowledge about tuberculosis than the account in chapter 1, or of the social background leading up to the organization in 1904 of the National Association for the Study and Prevention of Tuberculosis than in chapter 2. If every board member and staff worker throughout the association would read these 58 pages, many things that may not now be understood would be clear.

Dr. Shryock has used a great amount of material in the NTA archives and elsewhere to describe the activities of such leaders as Flick, Biggs, Knopf, Trudeau, Osler, and scores of others. He has also traced the relationship between the association and the international tuberculosis movement, and has devoted considerable attention to the development of the medical research program.

The book closes with a remarkably fine résumé of the role that our associations have played "as heirs of the preceding century" and yet as organizations that introduced "novel elements." The reader is left with the sober thought that "the very advances of recent decades impose additional and pressing problems of control and research."

Reading this book should be a pleasure, a privilege, and a real help for all tuberculosis workers.

P

Morris Barrett has been appointed an associate in the Program Development Division of the National Tuberculosis Association. He will be in charge of developing the program on respiratory illness and air hygiene. Mr. Barrett has been director of the Grand Rapids (Mich.) Alcoholism Rehabilitation Center, public health educator with the Grand Rapids City Health Department, and a school health administrator in New York City.

Miss Edwina F. Johnson will become an associate in the Seal Sale Division of the National Tuberculosis Association in October. Miss Johnson is presently a field consultant with the New Jersey Tuberculosis and Health Association and was formerly executive secretary of the Staten Island (N.Y.) Tuberculosis and Health Committee.

Dr. Alan Gregg, who served for 20 years as chief of the division of medical sciences for the Rockefeller Foundation, died on June 12, at 66.

William Becque, formerly executive director of the Tuberculosis and Health Association of the New Haven (Conn.) Area, has resigned to become director of the Community Services of the District of Columbia Tuberculosis Association, Washington, D. C. He will be replaced by **Kenneth E. Jacobs,** formerly program coordinator of the Marion County (Ind.) Tuberculosis Association.

Mrs. Margaret Haun has been appointed executive secretary of the York County (S.C.) Tuberculosis Association, replacing **Miss Winnie Morrison.**

Daniel T. Marley, executive director of the Bernalillo County (N.M.) Tuberculosis Association, has been elected president of the New Mexico Public Health Association—the first voluntary agency person in New Mexico to hold such a position in many years.

Dr. Murray P. Horwood, professor of sanitary science at Massachusetts Institute of Technology and a leader in the public health field, died on June 4.

Dr. S. A. Slater, a member of the board of the National Tuberculosis Association and superintendent of the Southwestern Tuberculosis Sanatorium in Minnesota, recently received two honors. The University of Richmond awarded him a Golden Legion Certificate of Merit in recognition of 50 years of service to the university since his graduation in 1907, and the Minnesota Medical Association presented him with a Citation of Appreciation for his pioneer service in tuberculosis control.

Thomas Connolly has rejoined the Onondaga (N.Y.) Health Association in his former capacity as executive secretary.

Miss Doris Johnson, formerly executive director of the Boston Division of the Massachusetts Tuberculosis League, has been appointed executive secretary of the Boston Tuberculosis Association following the amalgamation of the division and the Boston association.

Mrs. Mildred O. Mantle has been appointed executive secretary of the Anchorage (Alaska) Tuberculosis Association.

Paul H. Neff, formerly director of public relations for the Maryland Tuberculosis Association, is now fund-raising director for the Heart Association of Maryland.

New officers have been elected by the following constituent tuberculosis associations:

Brooklyn: President, **Edward T. Fagan;** vice presidents, **Hon. Raymond A. Tierney, Maurice Wollin,** and **Mrs. Wallace B. White;** secretary, **Mrs. Dorothy C. Spaulding;** treasurer, **John W. Raber;** assistant treasurer, **Clinton L. Miller.**

Idaho: President, **Leslie T. McCarthy;** first vice president, **Oscar W. Nelson;** second vice president, **Dr. James Kircher;** third vice president, **Dr. C. Dean Packer;** treasurer, **A. B. Wheeler;** recording secretary, **Mrs. Hugh Caldwell.**

Kentucky: President, **John W. Woods;** first vice president, **Howard Hunt;** second vice president, **Theodore Sanford;** third vice president, **Dr. Asa Barnes;** secretary, **Miss Lois Leslie;** treasurer, **Dr. E. N. Maxwell.**

Maryland: President, **William A. Rowe;** first vice president, **Frank J. Fischer;** second vice president, **Dr. Moses S. Shiling;** secretary, **Mrs. John E. Baybutt;** treasurer, **Lucien E. D. Gaudreau;** assistant treasurer, **Mrs. Aaron M. Libowitz.**

Mississippi: President, **Mrs. C. D. Williams;** president-elect, **C. M. Schneideau;** vice president, **Dr. B. D. Blackwelder.**

Queensboro: President, **Dr. James Edward Lowry,** first vice president, **Godias J. Drolet;** second vice president, **William J. Rigney;** secretary, **Mrs. H. E. Hendrickson;** treasurer, **Dr. Daniel Porte;** first assistant treasurer, **Gregor J. Schaefer;** second assistant treasurer, **Charles Belous.**